No. 17-8151

In the Supreme Court of the United States

RUSSELL BUCKLEW,
Petitioner,

v.

ANNE L. PRECYTHE, DIRECTOR,
MISSOURI DEPARTMENT OF CORRECTIONS, *et al.*,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit

BRIEF OF AMERICAN MEDICAL ASSOCIATION, *AMICUS CURIAE*, IN SUPPORT OF NEITHER PARTY

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INTEREST OF *AMICUS*[1]

The American Medical Association (AMA) is the largest professional association of physicians, residents and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all physicians, residents, and medical students in the United States are represented in the AMA's policy making process. The AMA was founded in 1847 to promote the art and science of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in every state and in every medical specialty.

The petitioner in this case, Mr. Russell Bucklew, asserts that he suffers from a rare and severe medical condition that will make his death by execution under the State of Missouri's standing execution protocol—death by lethal injection—cruel and inhumane. Instead, he asks the State to execute him by lethal gas. The State contends that in order to succeed on this claim he must show that the alternative method is readily available and will "substantially reduce the risk of severe pain," and that he has not done so because he has failed to offer sufficient evidence that one method is preferable over another. Brief in Opposition to Petition for Writ of Certiorari and in

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[1] The parties have consented to the filing of this brief. No party's counsel authored this brief in whole or in part. No party or counsel for a party made a monetary contribution intended to fund the preparation or submission of the brief. No person other than the AMA made a monetary contribution.

Opposition to Application for Stay of Execution at 28-36. Dr. Joel Zivot, an expert witness for Mr. Bucklew, felt ethically unable to compare the medical consequences of the alternative forms of execution allowed under Missouri law, and thus, according to the State, Mr. Bucklew failed to carry his burden of proof. Petition for Writ of Certiorari at 15.

This brief, submitted in support of neither party, is intended to lend context to Dr. Zivot's ethical stance. Physicians are members of a profession dedicated to preserving life, even when the hope of doing so is slight. Although state-mandated death is *not* a medical procedure, society continually attempts to medicalize this action in a self-deceiving effort to mitigate its barbarity.

The AMA uses this opportunity to restate the prohibition against physician participation in executions and explain the historic and modern rationales behind its position. Furthermore, as the publisher of the *AMA Code of Medical Ethics*,[2] the AMA has an interest in supporting physicians who behave ethically and in explaining the rationale behind the ethical positions of the medical profession.

Most importantly, though, the AMA believes the public should appreciate, on an important topic like capital punishment, what medical science knows and what it does not know. The decision to authorize execution should be based on a frank evaluation of that

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[2] The *AMA Code of Medical Ethics* is available from the AMA in print form and also through the AMA website at https://www.ama-assn.org/delivering-care/ama-code-medical-ethics.

uncertainty, rather than on a mistaken notion of what may be unduly characterized as "humane" or "dignified."

SUMMARY OF ARGUMENT

Starting with its origins at the time of Hippocrates, the medical profession has staunchly opposed physician assistance in state-mandated executions. This prohibition is based on more than happenstance or arbitrary tradition. Physician participation in capital punishment undermines the trust patients must accord their physicians in order for physicians to practice effectively. Furthermore, physician participation in executions falsely suggests to society that capital punishment can be carried out humanely, with the endorsement of the medical profession. Physicians should not further such a charade. Accordingly, Dr. Zivot is correct—testimony used to determine which method of execution would reduce physical suffering would constitute physician participation in capital punishment and would be unethical.

In addition, notwithstanding that technical medical issues may well underlie this Court's ultimate decision, the AMA declines to comment on those issues or to advocate for either party as to which method of death may be constitutionally preferred. The reasons for this "no position" stance are the same as those which underlay Dr. Zivot's prohibition: the AMA, being an organization of physicians, cannot ethically support or facilitate either method of capital punishment.

ARGUMENT

I. It Would Be Unethical for a Physician to Assist a Court or Executioner in Devising a Method of Capital Punishment by Testifying About the Comparative Levels of Pain a Condemned Prisoner Would Likely Suffer Under Alternative Execution Scenarios.

A. Physicians Are Ethically Prohibited from Participating in Execution by the Historic and Prevailing Standards of the Medical Profession.

The practice of medicine is a skilled profession anchored in the core ethical precept of beneficence to the patient. Thus, the Preamble to the Principles of Medical Ethics states: "The medical profession has long subscribed to a body of ethical statements developed primarily for the benefit of the patient."[3] One of the defining characteristics of any profession is the ability to self-regulate.[4] In return, members of the profession are committed to using their skills in a manner that upholds the integrity of their profession. Therefore,

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[3] The Principles of Medical Ethics and their Preamble are part of the *AMA Code of Medical Ethics*.

[4] "[Physicians] are governed by codes of ethics and profess a commitment to competence, integrity and morality, altruism, and the promotion of the public good within their domain. These commitments form the basis of a social contract between a profession and society, which in return grants the profession a monopoly over the use of its knowledge base, the right to considerable autonomy in practice and the privilege of self-regulation." Sylvia R. Cruess et al., *"Profession": A Working Definition for Medical Educators*, 16 TEACH. LEARN. MED. 74, 74-76 (2004).

unsurprisingly, medical ethics are as old as the practice of medicine itself, passed to future generations through medical training, and predating and prevailing regardless of government-sponsored licensure. Ethics codes in medicine have developed across "virtually all" ancient civilizations, time periods, and independently of one another,[5] and resurged as reminders to the profession of medicine's core responsibility when physician conduct falls below its contract to society.

In the 5th Century BCE, early practitioners of medicine swore an oath to the gods of the day to ground their practice in service to the best interest of their patients. HIPPOCRATIC OATH, https://goo.gl/3k4CMc (last visited Jul. 18, 2018) ("I will. . .benefit my patients according to my greatest ability and judgement, and I will do no harm or injustice to them"). The Hippocratic Oath included this vow: "I will not give a lethal drug to anyone if I am asked, nor will I advise such a plan." *Id.*

Modern versions of the oath no longer make promises to the gods of antiquity, but they keep to the same principles of duty to humanity as a whole and to the individual patient—not to a government edict or a political doctrine. The oath serves as an important reminder that physicians wield a potent skill, and they must do so humanely and not as technicians: "I will remember that there is art to medicine as well as

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[5] Although less famous than the Hippocratic oath, the medical fraternities of ancient India, seventh-century China, and early Hebrew society each had medical oaths or codes that medical apprentices swore to on professional initiation. Thomas Tung & Claude H. Organ, Jr., *Ethics in Surgery: Historical Perspective*, 135 JAMA 10, 10 (2000).

science, and that warmth, sympathy, and understanding may outweigh the surgeon's knife or the chemist's drug. . .that I do not treat a fever chart, a cancerous growth, but a sick human being." *See* Peter Tyson, *The Hippocratic Oath Today*, NOVA (Mar. 27, 2001), *available at* https://goo.gl/V2X7Up.[6]

The *AMA Code of Medical Ethics* was the first modern national medical ethics code in the world. *See* TUNG & ORGAN, JR., *supra* note 5. It is today the most comprehensive and well respected ethical code for physicians anywhere.[7] Ethical Opinion 9.7.3 *Capital Punishment*,[8] which sets forth the ethical position on

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[6] The modern version of the Hippocratic Oath was written in 1964 by Dr. Louis Lasagna while serving as Academic Dean of the School of Medicine at Tufts University. *Id.* Dr. Lasagna's oath is used by approximately one-third of US and Canadian medical schools. Melissa Bailey, *So Long, Hippocrates. Medical Students Choose Their Own Oaths*, STAT (Sep. 21, 2016), https://goo.gl/YMF3Ls.

[7] This Court and its individual justices have repeatedly relied on and cited to the *AMA Code of Medical Ethics* as guidance. *Lilly v. Commissioner*, 343 U.S. 90, 97 n.9 (1952); *Roe v. Wade*, 410 U.S. 113, 144 n.39 (1973); *Bates v. State Bar of Ariz.*, 433 U.S. 350, 369 n.20 (1977); *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 288 & 308 (1990) (O'Connor, J., concurring & Brennan, J., dissenting); *Rust v. Sullivan*, 500 U.S. 173, 214 (1991) (Blackmun, J., dissenting); *Washington v. Glucksberg*, 521 U.S. 702, 731 (1997); *Vacco v. Quill*, 521 U.S. 793, 800 n.6 & 801 (1997); *Ferguson v. City of Charleston*, 532 U.S. 67, 81 (2001); *Baze v. Rees*, 553 U.S. 35, 64 & 112 (2008) (Alito, J., concurring & Breyer, J., concurring); *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 592-93 (2012) (Ginsburg, J., dissenting).

[8] Ethical Opinions are determinations by the AMA Council on Ethical and Judicial Affairs of the AMA's positions on specific ethical issues. They are a part of the *AMA Code of Medical Ethics*.

physicians' participation in capital punishment, includes the following proscription:

> Debate over capital punishment has occurred for centuries and remains a volatile social, political, and legal issue. An individual's opinion on capital punishment is the personal moral decision of the individual. However, as a member of a profession dedicated to preserving life when there is hope of doing so, a physician must not participate in a legally authorized execution.

The AMA is not alone in its position. Whenever any medical body has addressed this question, the answer has remained the same; it is unethical to use the skills and training developed to care for the patient in order to kill at the request of the state. Timothy F. Murphy, *Physicians, Medical Ethics, and Capital Punishment*, 16 J. CLIN. ETHICS 160, 161 (2005) ("It does not appear that any professional medical group that has considered the matter has ever come to a different conclusion.").

Thus, the American College of Correctional Physicians, which represents physicians who provide health care services to incarcerated patients, states in its Code of Ethics that "[t]he correctional health professional shall . . . not be involved in any aspect of execution of the death penalty." ACCP CODE OF ETHICS, https://goo.gl/DVjkD5 (last visited Jul. 18, 2018). The American College of Physicians states in its Ethics Manual that "[p]articipation by physicians in the execution of prisoners except to certify death is unethical." AMERICAN COLLEGE OF PHYSICIANS: POLICY COMPENDIUM, https://goo.gl/e7ckDx (last visited

Jul. 18, 2018). The American Public Health Association has formally announced its policy position that "health professional participation in executions or pre-execution procedures is a serious violation of ethical codes." Am. Public Health Ass'n, Participation of Health Professionals in Capital Punishment, Policy Number 200125 (Jan. 2001). The American Society of Anesthesiologists has taken the position that "[i]t is a fundamental and unwavering principle that anesthesiologists, consistent with their ethical mandates, cannot use their art and skill to participate in an execution." Brief of *amicus curiae* American Society of Anesthesiologists Supporting Neither Party at 10-11, Baze v. Rees, 553 U.S. 35 (2008). The American Psychiatric Association has stated in its Principles of Medical Ethics that "[a] psychiatrist should not be a participant in a legally authorized execution." Am. Psychiatric Ass'n Principles of Med. Ethics § 1-4 (2013). At the international level, the World Medical Association, an organization whose members include approximately eighty national medical associations, asserts that "it is unethical for physicians to participate in capital punishment, in any way, or during any step of the execution process." 63rd Gen. Assembly of the World Med. Ass'n, *in* WMA Resolution to Reaffirm the WMA's Prohibition of Physician Participation in Capital Punishment (Oct. 2012).

In fact, this Court has itself acknowledged the ethical prohibition on physician participation (and participation by other health care professionals) in capital punishment. *Baze v. Rees*, 553 U.S. 35 (2008) (plurality), *Baze*, 553 U.S. at 63 (Alito, J., concurring), and 553 U.S. at 107 (Breyer, J., concurring).

B. Physician Assistance in the Design of Executions Would Undermine the Physician-Patient Relationship.

Medical ethics are not mere relics of antiquity; they form the foundation of medicine as a self-regulating profession. Codified ethics serve as reminders of the contract physicians have made to their patients and the community they serve to use their training for the good health of humanity. Most importantly, they demonstrate to the public that physicians can be trusted to provide the most intimate care, since the basis of the treating relationship is patient trust in the physician. *AMA Code of Medical Ethics* Opinion 1.1.1. *Patient-Physician Relationships* ("[t]he relationship between a patient and a physician is based on trust."). The physician has a duty to place the patient's welfare above other obligations, like the obligation to the state. *Id.* And, physicians must consider how their decisions reflect on the profession and upon other health care professionals. Preamble to the Principles of Medical Ethics. This relationship cannot be overstated. "Unless there is complete confidence in the sympathetic understanding of the physician as well as in his professional skill, very little can be accomplished." Francis W. Peabody, *The Care of the Patient*, 88 JAMA 877, 882 (1927).

Patient trust must be nurtured. Physicians who participate in executions at the expense of ethical rules risk confusing their responsibility to the patient with a responsibility to the state. If patients feel they cannot trust the independent judgment of their physician, they may avoid necessary medical care or withhold sensitive information from the physician. Scheduling, attending,

and following up on medical care is already stressful and time consuming for patients; the public does not need another barrier in access to health care.

Even ancillary involvement in execution by physicians risks jeopardizing public trust in the profession. Dr. Atul Gawande recorded that when one community learned that its local doctor participated in executions, the physician found a note posted to his clinic's door reading, "the killer doctor." Atul Gawande, *When Law and Ethics Collide: Why Physicians Participate in Executions*, 354 N. ENG. J. MED. 1222, 1225 (2006). He went on to state,

> The public has granted us extraordinary and exclusive dispensation to administer drugs to people, even to the point of unconsciousness, to put needles and tubes into their bodies, to do what would otherwise be considered assault, because we do so on their behalf—to save their lives and provide them comfort. To have the state take control of these skills for its purposes against a human being—for punishment—seems a dangerous perversion. Society has trusted us with powerful abilities, and the more willing we are to use these abilities against individual people, the more we risk that trust. The public may like executions, but no one likes executioners.

Id. at 1227.

Moreover, this Court recently noted that governments throughout history have attempted to corrupt the physician-patient relationship to "increase state power." *NIFLA v. Becerra*, No. 16-1140, slip op. at

12-13 (U.S. Jun. 26, 2018) ("In Nazi Germany, the Third Reich systematically violated the separation between state ideology and medical discourse. German physicians were taught that they owed a higher duty to the 'health of the Volk' than to the health of individual patients.") (citation omitted). The end result was a legal, physician-designed "killing program" credited as the "crucial step that led to the atrocities of Auschwitz." Robert D. Troung & Troyan A. Brennan, *Sounding Board: Participation of Physicians in Capital Punishment*, 329 N. ENG. J. MED. 1346, 1348-49 (1993).

The AMA is acutely aware of this stain on the medical profession. By refusing to participate in capital punishment, even when sanctioned by a free society, physicians are making a statement—even if symbolically—that their role is not to serve the state as experts in killing, but to minister to their patients as healers. Ethical physicians avoid any potential blurring of these fundamentally incompatible functions.

Thus, it is no coincidence that the Hippocratic Oath included a prohibition on using medical skills to cause death. Early physicians well foresaw the potential for society to co-opt their training to perform in the best interests of the state and not of the patient. To render technical advice in executions would be to step down a slippery slope. Somewhere near the bottom of that hill would be a loss of patient trust and an undermining of the patient-physician relationship.

C. Physician Participation in Executions Would Falsely Suggest that Capital Punishment can be Effectuated Humanely, with the Endorsement of the Medical Profession.

If the goal in performing executions were merely getting the job done quickly, cheaply, and with minimal pain, the problem of how to administer capital punishment would be readily resolved. Long before Dr. Guillotin advocated for his eponymous device, society knew how to conduct swift and certain beheadings.[9] The problem with beheadings, though, is that they are gruesome. They force the public to confront the enormity of the act.

What people much prefer is a way to accomplish the deed while believing there is something humane about it. Society wants to delude itself into a belief that capital punishment no longer represents a weighted moral choice, but is now somehow scientific—nearly antiseptic. This delusion, however, cheapens life and makes its extinction easier. The medical profession,

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[9] Dr. Joseph-Ignace Guillotin opposed the death penalty on principle, but wanted all criminals executed as painlessly as possible, and equitably, without exception for the aristocratic classes. *See* Dora B. Weiner, *The Real Doctor Guillotin*, 220 JAMA 85 (1972). He advocated for the use of "a simple mechanism" to replace burning alive, hanging, quartering, drowning and other slow and agonizing methods. *Id.* Unfortunately for Dr. Guillotin: "No one. . . could foresee in that winter of 1789 that the Revolution would go beyond the creation of a constitutional monarchy, nor that leaders of political factions would put their opponents to death for deviating from the party line." *Id.* at 89.

whose "essential quality" is an interest in humanity[10] and which reveres human life, should have no part in this charade.

In the United States, the prohibition on physician participation in execution was not done simply to honor the Hippocratic injunction, but more directly as the result of this country's century long march from hanging toward the overt imitation of medical practice in state sponsored execution protocols—always in search of the most "humane" way to kill. The goal of so-called humanity in execution has infamously lured several well-meaning physicians, even aside from Dr. Guillotin, down the road to ethical peril. Physicians have measured the length of rope in an effort to achieve precision in hangings and avoid decapitation. *See* Mahmoud Rayes et al., *Hangman's Fracture: A Historical and Biomechanical Perspective*, 14 J. NEUROSURG. SPINE 198, 205 (2011). While it was a dentist who designed the electric chair for execution, it was physicians who advised on the "proper length of time to apply electricity" while attending the first such execution. Christopher J. Levy, *Conflict of Duty: Capital Punishment Regulations and AMA Medical Ethics*, 26 J. LEGAL MED. 261, 263 (2005). An army medical corps officer invented the gas chamber in 1924 after the original plan of surprise gassing of prisoners in their cells was deemed "impractical." Meghan S. Skelton, *Lethal Injection in the Wake of* Fierro v. Gomez, 19 T. JEFFERSON L. REV. 1, 8 (1997).

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[10] PEABODY, *supra*, at 882.

Each time, the well-intentioned physician started with the goal of reducing the barbarity of the previous method, and each time history later deemed that physician's method to be outdated and unfit for a humane society. *See* Joan M. LeGraw & Michael A. Grodin, *Health Professionals and Lethal Injection in the United States*, 24 HUMAN RIGHTS Q. 382, 396-97 (2002). If these attempts teach us nothing else, it is that the physician has no place in designing death when the purpose of the profession and the doctor's training is to preserve life.

Yet, states have attempted to "medicalize" executions by "intentionally mimic[king] medical procedure, thereby deceiving physicians who imagine a medically necessary role, and the public which imagines safe oversight." Joel B. Zivot, *Lethal Injection: States Medicalize Execution*, 49 U. RICH. L. REV. 711, 719 (2015).[11] States have ordered condemned prisoners to sign Do Not Resuscitate orders in anticipation of execution, and mandated the presence of doctors wearing white coats and stethoscopes to give an air of "seriousness and safety." *Id.* In order to sidestep this ethical crisis, states have passed safe harbor laws to shield physician participants who choose to violate professional ethics from state licensure boards or have determined that physicians who participate in

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[11] Dr. Zivot, who authored this law review article, is the same Dr. Zivot who examined Mr. Bucklew and prognosticated on his medical condition if he were to be executed under the present Missouri protocol.

executions are not practicing medicine. *Id.*[12] This Court has itself recognized the progression from colonial methods of killing to the modern trend of medicalized death, supposedly in the pursuit of humanity. *Baze*, 553 U.S. at 41-44 (plurality); *Glossip v. Gross*, 135 S. Ct. 2726, 2731-32 (2015).

A comparison between the plurality opinion in *Baze v. Rees*, 553 U.S. 35 (2008), and the concurrence of Justice Stevens in the same case may further illuminate this issue. The plurality recounts the history of methods of execution in the United States. *Id.* at 41-44. It characterizes that history as a persistent progression, guided by the latest scientific insights, toward an ever more humane and dignified method of extinguishing human life. *Id.* Eventually, the plurality notes, the vast majority of states have settled upon death by lethal injection, involving the use of three drugs: sodium thiopental (to anesthetize), pancuronium bromide (to paralyze), and potassium chloride (to stop the heart, in case the first two drugs failed to do the job). *Id.* at 44. It sums up this progression as follows:

> Our society has. . .steadily moved to more humane methods of carrying out capital

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[12] For a list of confidentiality laws by state *see* State by State Lethal Injection, DEATH PENALTY INFORMATION CENTER, https://goo.gl/ZxhVS7 (last visited Jul. 18, 2018). *See also N. Carolina Dep't of Correction v. N. Carolina Med. Bd.*, 675 S.E.2d 641, 651 (2009) (holding that North Carolina's execution protocol required physician involvement in execution, and that the state medical board exceeded its statutory authority when it threatened to enforce the ethical prohibition on physician participation in capital punishment).

> punishment. The firing squad, hanging, the electric chair, and the gas chamber have each in turn given way to more humane methods, culminating in today's consensus on lethal injection. The broad framework of the Eighth Amendment has accommodated this progress toward more humane methods of execution, and our approval of a particular method in the past has not precluded legislatures from taking the steps they deem appropriate, in light of new developments, to ensure humane capital punishment. There is no reason to suppose that today's decision will be any different.

553 U.S. at 62 (citation omitted).

In his concurrence, Justice Stevens saw the matter a bit differently. He suggested that the injection of pancuronium bromide *might* have the effect of hastening the execution, but it also *might* have the effect of allowing the prisoner to die in horrific agony. *Baze*, 553 U.S. at 71-77 (Stevens, J., concurring). The likelihood of either outcome cannot be known within any reasonable medical certainty. What is known, though, is that pancuronium bromide will prevent muscular twitching by the prisoner (whether dead or alive). The pancuronium bromide injection, then, will certainly preserve the executioner's own sense of dignity and humanity in carrying out the execution (and offer similar comfort to the society that has ordered the execution), but it might well have the opposite effect for the prisoner. As Dr. Zivot stated, "the dead can never tell us if they experienced cruelty in their death[;] the responsibility to guard against

cruelty is entirely in the hands of the observers." ZIVOT, *supra*, at 714.

Ultimately, the morality of capital punishment is a matter of personal judgment, beyond the pronouncements of the medical profession and of this Court. What is not beyond the AMA or this Court, though, is an objective, even-handed evaluation of the process, with a frank confession of what is knowable and what is not. As of November 2016, 31 states and the federal government authorized legal executions. *See* States With and Without the Death Penalty, DEATH PENALTY INFORMATION CENTER, https://goo.gl/ogXhC1 (last visited Jul. 18, 2018). With due respect, the AMA wonders how that number might change if the leaders of society, including the members of the judiciary, were less enthusiastic about labeling the changes to execution protocols as scientific improvements and were more discerning in their use of terms like "humane" and "dignified."

II. *Amicus* Takes No Position on the Substantive Issues, Including the Medical Questions that Underlie this Case.

The certified questions ask how the Eighth Amendment constrains the allowable method of execution for Mr. Bucklew, on account of his "rare and severe medical condition." Due to the prohibitions in the *AMA Code of Medical Ethics*, as discussed in this brief, the AMA is unable to provide guidance on that medical condition. Similarly, the AMA is unable to support either party or recommend how the Eighth Amendment should apply in this case.

CONCLUSION

Some, at least, of the certified questions in this case concern whether Mr. Bucklew has been able to prove, based on the idiosyncrasies of his own medical condition, which is the most legally suitable procedure for his own execution. In determining whether the prisoner has met his burden, the Court may choose to consider the consequences of the ethical prohibition against physicians' rendition of technical advice regarding the alternative possibilities for an execution. This brief, which is submitted on behalf of neither party, is intended only to provide background on the applicable ethical principles and to confirm, as noted *supra*, that Dr. Zivot is correct—testimony used to determine which method of execution would reduce physical suffering would constitute physician participation in capital punishment and would be unethical.

Respectfully submitted,

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